STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155241	A. BUILDING 01 B. WING	09/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CREEK VILLAGE	525 E THOMPSON ROAD INDIANAPOLIS, IN46227

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/21/11 Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Forest Creek Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors. The facility has battery operated smoke detectors in all resident	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Life Safety Code Post Survey Review on or after October 21, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sleeping rooms. The facility has a capacity of 128 and had a census of 123 at the time of this visit. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 13 doors serving hazardous areas such as storage rooms greater than fifty square feet in size which are used to store combustible materials and the laundry are equipped with self closing devices on the entry doors and each door latches into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the activities area storage room and the laundry room. Findings include:	K0029	A self closing device was installed to the Activities Storage Door on 10/4/2011. The latching mechanism to the laundry room door was adjusted on 9/22/2011 to ensure full closure within the door frame when released. All doors with self closing devices will be checked weekly by Maintenance Director or designee to ensure proper closure. Any door found without properly working mechanisms will be adjusted and/or repaired immediately. Repairs unable to be correctied immediately will be reported to the Administrator to ensure a qualified technician repairs door(s), as applicable to	10/21/2011

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	a. Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:25 p.m. on 09/21/11, the activities area storage room measures sixty square feet, is used to store combustible boxes and supplies and the entry room door is not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Director acknowledged the activities area storage room measures greater than fifty square feet, is used to store combustible supplies and the entry door is not equipped with a self closing device. b. Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:25 p.m. on 09/21/11, the laundry room west door is equipped with a self closing device and positive latching mechanisms, but, the west laundry room door failed to latch into the door frame. Based on interview at the time of observation, the Maintenance Director stated the latching mechanism on the west door was not aligning with the latch plate and acknowledged the west laundry room door failed to latch into the door frame.		working order. Maintenance Director or designee will conduct weekly rounds to ensure all doors with self closing devices have full closure within door frames when released. Maintenance Director or designee will educate staff on ensuring doors close properly upon self release. Maintenance Director or designee will conduct monthly fire drill, where doors with self-closing devices are checked to ensure proper closure when fire system is tested. Results of weekly rounds and fire drill reports will be reviewed monthly in Continuous Quality Improvement (CQI) meeting by the CQI committee, which consists of the Administrator, Director of Nursing, Medical Director, Staff Development Coordinator (SDC), and other disciplinary team members. CQI committee will review reports monthly x 4, then bi-monthly x 2, then quarterly x 2. If threshold not met, an action plan will be developed.	
K0048 SS=C	3.1-19(b) There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1			

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	Based on record review, interview and observation; the facility failed to include the use of K class kitchen fire extinguishers in the written plan for the protection of 123 of 123 residents in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects all residents in the facility. Findings include: Based on a review of the facility's written fire disaster plans labeled "Disaster Action Plan: Fire Prevention" and "General Fire Action Plan" for Forest Creek Village on 09/21/11 at 10:30 a.m. with the Maintenance Director, each written fire disaster plan did not address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system.	K0048	Facility fire and disaster plan will be updated to include the use of K class fire extinguisher, which is located in the kitchen. Maintenance Director or designee will educate staff on use of the K class extinguisher, including the location of instructions for use. Staff will be educated on facility fire plan upon hire and at least 2 times annually. Fire and disaster plan training will be included on Annual In-service Calendar. CQI committee will review fire and disaster plan to ensure instructions for use of K class extinguisher is present by 10/21/2011, and at least annually by CQI committee.	10/21/2011

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	Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:25 p.m., one K class fire extinguisher is located in the kitchen. Based on interview at the time of record review, the Maintenance Director acknowledged the facility's fire disaster plans did not address the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system.			
K0056 SS=E	3.1-19(b) If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA 13, Section 5-6.3.4, "Minimum Distance between Sprinklers", states sprinklers	K0056	Sprinkler heads were installed in the Maintenance Room to ensure spacing was not less than 6 feet on center. Facility rounds were conducted by Maintenance Director to ensure the minimum distance between sprinklers was spaced not less than 6 feet on center. All facility sprinklers were met within regulation. Monthly fire system testing will be conducted by Maintenance	10/21/2011

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	shall be spaced not less than 6 feet on center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect residents, staff or visitors in the vicinity of the Maintenance Room. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:45 p.m. on 09/21/11, two sprinkler heads suspended from the ceiling are installed one foot from each other in the Maintenance Room above the water heater. Based on interview at the time of observation, the Maintenance Director acknowledged these two sprinkler head locations in the Maintenance Room above the water heater were installed less than 6 feet apart on center. 3.1-19(b)		Director or designee. Any abnormal reports or rounds conducted will be reported to Administrator to ensure a qualified technician corrects any findings. Monthly, quarterly, and annual protection equipment testing will be performed and recorded by Maintenance Director or designee, and/or qualified Fire Safety Company to ensure system is properly maintained. Records of inspections with abnormal findings will be reviewed during CQI meeting. If threshold not met, action plan will be developed.	

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K0074 SS=E	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 1. Based on record review, observation and interview; the facility failed to provide written documentation of the flame resistance for window curtains in the conference room and in the Office Manager's room. LSC 10.3.1 states curtains shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect any resident, staff or visitor in the vicinity of the conference room near the main entrance and near the Office Manager's room. Findings include: Based on review of "FireTect	K0074	Window curtains in the conference room and Office Manager offices were treated with a flame resistant solution and recorded by the Director of Housekeeping and Laundry Services. A shower curtain with mesh opening, extending 18 inches below the top panel was ordered for the spa room. The curtain will be installed on or before 10/21/2011. All draperies and curtains in resident rooms and offices will be treated with a flame resistant solution. A log to document treatment will be recorded and maintained by the Director of Laundry/Housekeeping or designee. All shower rooms were checked to ensure shower curtains allow 18 inch clearance for sprinkler deflector is in place. SDC or designee will educate	10/21/2011

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	Safe-T-Guard" documentation with the Maintenance Director and Housekeeping Manager during record review from 9:10 a.m. to 11:15 a.m. on 09/21/11, the facility applies this flame resistant solution to window curtains in the facility but does not keep documentation of the location of window curtains treated or the frequency of application. Based on interview at the time of record review, the Housekeeping Manager stated window curtains are used in some resident areas but acknowledged no documentation of the location of each window curtain treated with the flame resistant solution or the frequency of application was available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:15 a.m. to 12:45 p.m. on 09/21/11, four window curtains in the conference room by the main entrance and three window curtains in the Office Manager's room across the corridor from the physical therapy room each had no documentation of the flame resistance for each curtain or documentation of the application of FireTect Safe-T-Guard. Based on interview at the time of observation, the Maintenance Director stated the facility sprays the curtains at regular intervals with FireTect Safe-T-Guard but acknowledged he did not know if the window curtains in these locations had been treated with the flame		Administrative staff to ensure facility communicates with residents and families policy and procedure regarding draperies and curtains, with respect to prevention. Housekeeping Director or designee will provide initial treatment to curtains or draperies, and again after laundering, in accordance with manufacturer's recommendations. Maintenance Director or designee will conduct monthly rounds to ensure proper shower curtains are in place.Abnormal findings of facility rounds will be reported to the CQI committee monthly for review and recommended actions. If threshold not met, an action plan will be developed.	

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	resistant solution. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure sprinklers in areas where cubicle curtains are installed were installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems in 1 of 3 spa rooms. This deficient practice could affect any resident, staff or visitor in the vicinity of the spa by Room 11. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:30 p.m. to 3:25 p.m. on 09/21/11, the spa by Room 11 is provided with one sprinkler head location and has four cubicle curtains each hung from the ceiling with no 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflector. Based on interview at the time of observation, the Maintenance Director acknowledged the four cubicle curtains in the spa by Room 11 blocked the coverage of the one sprinkler head location. 3.1-19(b)			

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K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure the reliable source documentation for the off site fuel source for 1 of 1 emergency generators included a statement of reasonable reliability of the natural gas delivery, the history and probability of an interruption of service and was signed by a person with the technical expertise to make the reliable source claim. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1, Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid Petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of offsite fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall	K0144	Facility Administrator contacted the Code Specialist at Gas Company supplier to obtain documentation as required by this regulation. Gas Company will provide documentation as required, including a statement of reasonable reliability of gas delivery and other required statements per Life Safety Code requirements.Facility will maintain documentation as required in the regulation form Gas supplier. A copy of the letter supplied to the facility will be maintained in facility contract binder. A copy will also be maintained by Maintenance Director or designee.Administrator or designee will review utility contracts, along with CQI committee as applicable, to ensure proper documentation is provided per LSC requirements. Contracts are reviewed at least annually, unless otherwise specified.	10/21/2011

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	be required, with provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all clients, staff and visitors. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents as well as staff and visitors. Findings include: Based on review of Citizens Gas' natural gas supplier letter dated 05/08/08 with the Maintenance Director during record review from 9:10 a.m. to 11:15 a.m. on 09/21/11, the natural gas provider letter was signed by the "Commercial Sales Consultant" and did not include a			

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	statement of reasonable reliability of the natural gas delivery and the history and probability of an interruption of service. Based on interview at the time of record review, the Maintenance Director stated the fuel source for the emergency generator was natural gas and acknowledged the natural gas provider letter did not include a statement of reasonable reliability of the natural gas delivery, the history and probability of an interruption of service and was not signed by a person with the technical expertise to make the reliable source claim. 3.1-19(b)			